United States Department of Labor
Employees' Compensation Appeals Board

V.C., Appellant	)	
and	)	**Docket No. 10-2101**
	)	**Issued: July 5, 2011**
U.S. POSTAL SERVICE, POST OFFICE, Lubbock, TX, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
ALEC J. KOROMILAS, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On August 10, 2010 appellant filed a timely appeal from a July 8, 2010 merit decision of the Office of Workers' Compensation Programs' hearing representative denying her occupational disease claim. Pursuant to the Federal Employees' Compensation Act[1] and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has established that her knee condition was causally related to factors of her employment.

FACTUAL HISTORY

On August 3, 2009 appellant, then a 54-year-old lead sales and service associate clerk, filed an occupational disease claim alleging that she sustained a right knee lateral meniscus tear and patellofemoral disease as a result of constant standing on concrete floors, twisting and

[1] 5 U.S.C. § 8101 *et seq.*

pushing heavy equipment at work. She first became aware of her condition and realized that it was caused by her employment on December 17, 2008. Appellant explained that she did not file her claim within 30 days because she used her personal insurance, but when she continued to experience pain after undergoing knee surgery she decided to file a claim.

In a supplemental statement, appellant described the development of her knee condition. She first noticed her knee pain in December 2008 and informed her supervisor. Appellant went to her physician two weeks later and was diagnosed with a meniscus tear on the outside of the right knee. She did not file a compensation claim because her physician did not accept workers' compensation. Appellant had knee surgery on January 22, 2009 and returned to work in March 2009. A month later, she began to experience knee pain again and was then diagnosed with a meniscus tear on the inside of her right knee. Appellant attributed her knee condition to the wear and tear of standing at a counter selling stamps, twisting and turning to pick up and deliver mail and pushing heavy equipment on concrete floors at work for many years. She stated that she worked 8 to 10 hours a day for five or six days a week.

In an August 18, 2009 letter, the employing establishment stated that appellant worked the mail window five to six hours a day and did distribution one to two hours a day, five days a week while standing on rubber mats on a tile floor. Appellant's window duties included waiting on customers who were mailing letters, flats and packages, applying postage and placing items into the appropriate container for dispatch. Her distribution duties included standing with an armful of flats and placing them into case separators for the carrier section. The employing establishment also provided leave analysis forms dated from January 2007 to July 2009.

In an August 31, 2009 letter, the Office advised appellant that the evidence submitted was insufficient to support her claim and requested additional information. It requested that she describe how often and for how long she performed her described work activities, her activities outside of her federal employment, her previous orthopedic injuries and the development of her claimed condition. The Office also asked that appellant provide a comprehensive medical report from her treating physician, which included results of examinations and tests, a firm medical diagnosis, the treatment provided and its effects and a physician's opinion, with stated medical rationale, regarding the cause of her claimed condition.

Appellant provided a description of her position and an undated and unsigned duty status report, which stated that she was unable to perform her regular duties.

Appellant also provided typed and handwritten medical records dated from December 17, 2008 to July 22, 2009 from Dr. Stephen A. Cord, a Board-certified orthopedic surgeon, a specialist in sports medicine. In December 17, 2008 and January 13, 2009 reports, Dr. Cord noted that she began experiencing knee pain in October 2008 and had been walking a lot in order to lose weight. Appellant described the pain as intermittent, sharp pain that was mostly lateral and extended up the leg and down, which mostly occurred when walking or getting up and down. Dr. Cord observed positive popping, locking and catching in her knee with no numbness or tingling. Upon examination, he noticed a big palpable Baker's cyst and a tender lateral and medial meniscus tear. Appellant's pedal pulse was negative and her ligaments were fine. Dr. Cord reviewed x-rays and a magnetic resonance imaging (MRI) scan report and diagnosed her with right knee lateral meniscus tear, tear of the medial meniscus and patellofemoral disease.

In a December 17, 2008 form, appellant noted that her right knee had bothered her for two months and checked "No" that it was not a work injury. She described the pain as severe with the most pain occurring during walking and rising up and down.

On January 22, 2009 Dr. Cord performed a right knee arthroscopic excision of tear of posterior horn medial meniscus, arthroscopic chondroplasty patellofemoral joint, medial femoral condyle (MCL) and arthroscopic major synovectomy on appellant's right knee. In a January 22, 2009 operation report, he noted her diagnoses were medical meniscus tear, osteochondral degeneration, patellofemoral joint, MFC and synovitis of her right knee.

In medical records dated February 3 to July 22, 2009, Dr. Cord reported appellant's recovery from knee surgery. In February 3 and 24, March 3, 10 and 24, April 28 and May 26, 2009 reports, he stated that she was recovering well from her surgery without signs of infection. Dr. Cord also observed some swelling, effusion, stiffness, medial-sided pain and decreased extension and flexion. Appellant reported that she was doing her home exercise program and taking aspirin for any pain. Beginning in February 24, 2009, she began receiving orthovisc and cortisone injections into the right knee for the pain but none of the treatments provided any relief. In a March 10, 2009 note, Dr. Cord reported that appellant did a lot of walking and her knee was still and painful.

In a July 21, 2009 report, Dr. Cord observed that appellant's flexion was painful and that her medial meniscus was catching. Appellant stated that her pain went away for a while after her last injection, but now she experienced pain when walking and had difficulty walking down any slopes. Dr. Cord ordered an MRI scan of the right knee to check for medial meniscus.

In a July 22, 2009 report, Dr. Cord reviewed appellant's MRI scan results and observed a tear of medial meniscus, partial tears of medial collateral ligament (MCL) and medial retinaculum with slight lateral patellar shift and tilt, osteochondral lesion of the MFC and osteoarthritis at the patellofemoral and femorotibial articulations and joint effusion with Baker's cyst. He diagnosed appellant with bilateral patellofemoral disease with a patellar tilt.

Appellant also provided MRI scan reports from Dr. Mark Sateriale, a Board-certified radiologist. In a December 18, 2008 MRI scan report of her right knee, Dr. Sateriale observed a small undersurface tear of the posterior horn of the medial meniscus and a small, superficial tear of the anterior horn of the lateral meniscus. He also noted a slight lateral patellar tilt and shift with no bone contusion, fracture or stress fracture and chondromalacia at the patellofemoral and femorotibial articulations. Dr. Sateriale diagnosed appellant with small undersurface tear of the posterior horn of the medial meniscus, possible small tear of the anterior horn of the lateral meniscus, partial tear of the medial retinaculum, chondromalacia and joint effusion.

In a July 21, 2009 MRI scan report, Dr. Sateriale observed a moderate-sized complex tear of the posterior horn and body of the medial meniscus, mostly involving the undersurface and a partial tear of the MCL. He also reported a large amount of marrow edema in the MFC surrounding a two centimeters (cm) osteochondral lesion at the weight bearing aspect of the MFC and a three cm Baker's cyst. Dr. Sateriale noted that appellant's anterior and posterior cruciate ligaments and tendons appeared normal. He diagnosed her with a moderate-sized complex tear of the posterior horn and body of the medial meniscus, partial tears of the MCL

and medial retinaculum with slight lateral patellar shift and tilt, osteochondral lesion of the MFC surrounded by marrow edema, osteoarthritis at the patellofemoral and femorotibial articulations and joint effusion with Baker's cyst.

On October 13, 2009 the Office received appellant's undated statement in response to its development letter. Appellant described her work duties as standing at a window clerk station for six to eight hours, preparing a register cart for two to four hours, throwing flats for two to three hours and putting out flats for two to three hours. Her activities outside of her federal employment included bowling once a week and walking 15 to 30 minutes two to three times a week. Appellant described the development of her knee condition, which she believed was a result of constant standing, walking, twisting and turning while working on concrete floors for 30 years. She explained that Dr. Cord diagnosed her with a meniscus tear on the outside of her right knee and performed knee surgery on her, but she did not file a claim because Dr. Cord did not accept workers' compensation payments. Appellant explained that she continued to have pain at work even after the surgery. She noted that she wore a brace and had at least three injections in her knee but none have provided any relief. Appellant stated that she filed her claim because she experienced knee pain after her surgery when she returned to work and continued the same standing, twisting and turning on her knee. She also resubmitted the medical records from Dr. Cord and Dr. Sateriale.

In a November 5, 2009 decision, the Office denied appellant's claim on the grounds of insufficient evidence establishing that her knee condition was causally related to her employment. It found that the medical evidence submitted did not provide a physician's opinion, with stated medical rationale, explaining how factors of her employment resulted in her knee condition.

In a November 16, 2009 letter, appellant, through her attorney, requested an oral hearing that was held on April 20, 2010. The hearing representative advised counsel that appellant needed to submit medical evidence with a physician's opinion, supported by medical rationale and based on a complete and accurate factual medical history, establishing that her claimed condition was a result of the identified employment factors. Counsel requested 30 days to continue to obtain the necessary medical evidence and the hearing representative agreed to leave the record open for 30 days. No further information was submitted following the hearing.

By decision dated July 8, 2010, a hearing representative affirmed the November 5, 2009 decision finding that appellant failed to establish that her right knee condition was causally related to factors of her employment. The hearing representative accepted appellant's description of her work duties, but found that she did not provide a physician's opinion on whether those accepted work factors caused or aggravated her knee condition.

LEGAL PRECEDENT

An employee seeking benefits under the Act[2] has the burden of proof to establish the essential elements of her claim by the weight of the reliable, probative and substantial evidence[3] including that she sustained an injury in the performance of duty and that any specific condition or disability for work for which she claims compensation is causally related to that employment injury.[4] In an occupational disease claim, appellant's burden requires submission of the following: (1) a factual statement identifying employment factors alleged to have caused or contributed to the presence or existence of the disease or condition; (2) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the employee.[5]

Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence.[6] Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on whether there is a causal relationship between the employee's diagnosed condition and the specified employment factors or incident.[7] The opinion of the physician must be based on a complete factual and medical background of the employee, must be one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the employment factors identified by the employee.[8]

An award of compensation may not be based on surmise, conjecture or speculation. Neither the fact that an employee's condition surfaced during a period of employment nor her belief that her condition was aggravated by her employment is sufficient to establish causal relationship.[9] The mere fact that work activities may produce symptoms revelatory of an underlying condition does not raise an inference of an employment relation. Such a relationship must be shown by rationalized medical evidence of a causal relation based upon a specific and

[2] 5 U.S.C. §§ 8101-8193.

[3] *J.P.*, 59 ECAB 178 (2007); *Joseph M. Whelan*, 20 ECAB 55, 58 (1968).

[4] *G.T.*, 59 ECAB 447 (2008); *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989); *M.M.*, Docket No. 08-1510 (issued November 25, 2010).

[5] *R.H.*, 59 ECAB 382 (2008); *Ernest St. Pierre*, 51 ECAB 623 (2000); *D.U.*, Docket No. 10-144 (issued July 27, 2010).

[6] *D.I.*, 59 ECAB 158 (2007); *I.R.*, Docket No. 09-1229 (issued February 24, 2010); *W.D.*, Docket No. 09-658 (issued October 22, 2009).

[7] *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 345 (1989).

[8] *B.B.*, 59 ECAB 234 (2007); *D.S.*, Docket No. 09-860 (issued November 2, 2009).

[9] *See Roy L. Humphrey*, 57 ECAB 238, 241 (2005); *Ruby I. Fish*, 46 ECAB 276, 279 (1994).

accurate history of employment conditions which are alleged to have caused or exacerbated a disabling condition.[10]

ANALYSIS

The Board finds that appellant failed to meet her burden of proof to establish that she sustained her knee condition as a result of her federal employment. The Office accepted that her job required constant standing at the clerk window, twisting and turning to sort mail and pushing heavy equipment on concrete floors. The Board affirms the Office's July 8, 2010 decision because the medical evidence is insufficient to establish that appellant's knee condition was causally related to these specific employment activities.

Appellant submitted various medical reports dated December 17, 2008 to July 22, 2009 by Dr. Cord, who treated her for complaints of knee pain and performed her knee surgery. Dr. Cord's reports however are of little probative value to establish causal relationship because he did not review appellant's employment activities or explain how her work duties, such as constant standing or twisting, could have caused her diagnosed knee condition. In fact he did not offer any opinion as to the possible cause of her knee condition. Dr. Cord diagnosed appellant with right knee lateral meniscus tear and patellofemoral disease, but none of his reports provided an opinion addressing whether her employing establishment duties caused or aggravated her knee condition. In noting appellant's complaints of knee pain, he did report that she had been walking a lot to lose weight however he did not even attribute her walking at work to any subjective complaints.

In addition, appellant provided MRI scan reports from Dr. Sateriale, who also diagnosed her with right knee lateral meniscus tear and patellofemoral disease. Again, these reports lack any history of employment history and lack an opinion regarding causal relationship. Neither physician offered an opinion as to whether appellant's knee condition was causally related to her federal employment. The Board has held that medical evidence, which does not offer any opinion regarding the cause of an employee's condition, is of limited probative value on the issue of causal relationship.[11] Thus, the record is void of a medical opinion demonstrating that appellant's employment caused or aggravated her knee condition or explaining the possible cause of her knee condition.

Finally, the Board notes that, in a December 17, 2008 form, appellant indicated that her knee condition was not a work injury. As previously mentioned, the mere fact that a condition manifests itself during a period of employment does not raise an inference of causal relationship. The question of causal relationship is a medical one and must be resolved by probative medical evidence.[12] The medical evidence of record does not contain probative medical opinion discussing how appellant's knee conditions were caused or aggravated by factors of her

[10] *Patricia Bolleter,* 40 ECAB 373 (1988).

[11] *A.D.,* 58 ECAB 149 (2006); *C.B.,* Docket No. 09-2027 (issued May 12, 2010); *J.F.,* Docket No. 09-1061 (issued November 17, 2009).

[12] *D.I.,* 59 ECAB 158 (2007); *Margaret Carvello,* 54 ECAB 498 (2003).

employment. Thus, appellant has not met her burden of proof to establish that she sustained right knee lateral meniscus tear and patellofemoral disease in the performance of duty.[13]

Appellant may submit new evidence or argument with a written request for reconsideration to the Office within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that appellant failed to meet her burden of proof to establish that she sustained right knee lateral meniscus tear and patellofemoral disease as a result of her federal employment.

ORDER

IT IS HEREBY ORDERED THAT the July 8, 2010 decision of the Office of Workers' Compensation Program is affirmed.

Issued: July 5, 2011
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board

[13] The Board notes that appellant submitted additional evidence to the file following the July 8, 2010 decision. Since the Board's jurisdiction is limited to evidence that was before the Office at the time it issued its final decision, the Board may not consider this evidence for the first time on appeal. *See* 20 C.F.R. § 501.2(c).